

OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinions, 1–2, were presented by Susan Dorr Goold, MD, Chair:

1. AMENDMENT TO E-8.061, “GIFTS TO PHYSICIANS FROM INDUSTRY”

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2013 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2-I-13, “Amendment to Opinion E-8.061, ‘Gifts to Physicians from Industry.’” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.061 Gifts to Physicians from Industry

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

- (a) Decline cash gifts in any amount from an entity that has a direct interest in physicians’ treatment recommendations.
- (b) Decline any gifts for which reciprocity is expected or implied.
- (c) Accept an in-kind gift for the physician’s practice only when the gift:
 - (i) will directly benefit patients, including patient education; and
 - (ii) is of minimal value.
- (d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students’, residents’, and fellows’ participation in professional meetings, including educational meetings, provided:
 - (i) the program identifies recipients based on independent institutional criteria; and
 - (ii) funds are distributed to recipients without specific attribution to sponsors. (II)

2. PROFESSIONALISM IN HEALTH CARE SYSTEMS

CEJA Opinion; no reference committee hearing.

HOUSE ACTION: FILED

INTRODUCTION

At the 2013 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 5-I-13, “Professionalism in Health Care Systems.” The Council

issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.131 Professionalism in Health Care Systems

Containing costs, promoting high quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage under treatment and over treatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations have an ethical responsibility to ensure that practices for financing and organizing the delivery of care:

- (a) Are transparent.
- (b) Reflect input from key stakeholders, including physicians and patients.
- (c) Recognize that over reliance on financial incentives may undermine physician professionalism.
- (d) Ensure ethically acceptable incentives that:
 - (i) Are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data, and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethical guidelines.
 - (ii) Are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities.
 - (iii) Are implemented in conjunction with the infrastructure and resources needed to support high value care and physician professionalism.
 - (iv) Mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
- (e) Encourage, rather than discourage, physicians (and others) to:
 - (i) provide care for patients with difficult to manage medical conditions;
 - (ii) practice at their full capacity, but not beyond.
- (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
- (g) Are routinely monitored to:
 - (i) identify and address adverse consequences;
 - (ii) identify and encourage dissemination of positive outcomes.

All physicians have an ethical responsibility to:

- (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
- (i) Advocate for changes in health care payment and delivery models to promote access to high quality care for all patients. (I, II, III, V)

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–8, were presented by Susan Dorr Goold, MD, Chair:

1. PHYSICIAN EXERCISE OF CONSCIENCE

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: REFERRED

This report is currently being considered for publication, so the content is not included in the Proceedings at this time.

Members of the American Medical Association may contact hod@ama-assn.org to request a copy, which may not be further distributed.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Prospectively notify patients about those services the physician declines to offer for reasons of deeply held, well-considered personal belief that a patient might otherwise reasonably expect the physician to provide.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethical guidelines.

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2. ETHICALLY SOUND INNOVATION IN MEDICAL PRACTICE

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

See Policy [H-140.844](#).

This report is currently being considered for publication, so the content is not included in the Proceedings at this time.

Members of the American Medical Association may contact hod@ama-assn.org to request a copy, which may not be further distributed.

RECOMMENDATION

In light of the foregoing considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Innovation in medicine can range from improving an existing intervention, to introducing an innovation in one's own clinical practice for the first time, to using an existing intervention in a novel way or translating knowledge from one clinical context into another. Innovation shares features with both research and patient care, but is distinct from both.

When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of techniques and interventions they offer to patients.

Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise;
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation;
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients; and
- (d) Be sensitive to the cost implications of innovation;
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:

- (f) Base recommendations on patients' medical needs;
- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills;
- (h) Recognize that in this context informed decision making requires the physician to disclose:
 - i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;
 - ii) why the physician is recommending the innovative modality;
 - iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;
 - iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy; and
 - v) what conflicts of interest the physician may have with respect to the recommended therapy.

- (i) Discontinue any innovative therapies that are not benefiting the patient; and

- (j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, the medical profession should:

- (k) Require that physicians who adopt innovative treatment or diagnostic techniques into their practice have appropriate knowledge and skills;
- (l) Provide meaningful professional oversight of innovation in patient care; and
- (m) Encourage physician-innovators to collect and share information about the resources needed to implement their innovative therapies effectively.

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3. RESTRICTIVE COVENANTS (RESOLUTION 9-A-13)

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 9-A-13 AND
REMAINDER OF REPORT FILED**
See Policy [H-140.842](#).

Resolution 9-A-13, “Restrictive Covenants,” introduced by the Minnesota Delegation and referred by the House of Delegates, asks that “our American Medical Association conduct an in-depth review of and update” Opinion [E-9.02](#) on restrictive covenants in physician contracts. This report by the Council on Ethical and Judicial Affairs (CEJA) summarizes key ethical and legal issues relating to the use of restrictive covenants in medicine and reviews relevant AMA ethics policy in this area.

INTRODUCTION

In the context of medical services, a restrictive covenant—commonly referred to as a noncompete agreement or a covenant not to compete—is a contractual provision between a physician and his or her employer that limits or prevents a physician’s practice of medicine. Generally, the restriction applies to a specific geographic area for a defined period of time following the termination or conclusion of the physician’s employment or the sale of the physician’s medical practice.^[1] Restrictive covenants are often implemented to prohibit a new physician from

leaving his or her employer and then establishing a competing practice in that particular vicinity while using information, skills, training, or patient contacts provided by the employer.[2] Likewise, they may be implemented to restrict competition against the purchaser of a physician practice.

The *Code of Medical Ethics* includes several opinions relevant to covenants not to compete. Opinion [E-9.02](#), “Restrictive Covenants and the Practice of Medicine,” holds that the restrictive covenants have the potential to restrict competition, disrupt continuity of care, and deprive the public of medical services.[7] Covenants-not-to-compete may be unethical if they are “excessive in geographic scope or duration” or fail to make “reasonable accommodation” of patients’ choice of physician. Opinion [E-9.021](#), “Covenants-Not-to-Compete for Physicians in Training,” addresses the use of restrictive covenants in the context of medical residency and fellowship programs, and prohibits training institutions from seeking noncompete guarantees in return for fulfilling their education obligations.[8] Finally, Opinion [E-6.11](#), “Competition,” encourages competition among physicians and other health care practitioners and identifies key criteria for ethically justifiable competition.[9]

TREATMENT OF RESTRICTIVE COVENANTS BY STATE COURTS

Restrictive covenants are strictly a matter of state law. State courts generally view restrictive covenants in employment contracts with considerable skepticism given that these agreements are seen as a potential restraint on trade.[1] Therefore, courts often decline to enforce restrictive covenants against employees unless the employer can demonstrate that the noncompete agreement falls within the parameters established by state law.[2] In assessing whether a restrictive covenant is legally enforceable, courts look at whether the employer has a protectable business interest beyond simply avoiding competition that justifies the use of a restrictive covenant, whether the covenant is reasonable in terms of the time and geographic restrictions it establishes, and whether enforcing the agreement would be otherwise contrary to public policy.[2,6] Even if a restrictive covenant is determined to be legally valid, a court may be hesitant to see this portion of the employment contract implemented for fear the restrictions may impede an employee’s ability to work and deprive the public of that employee’s skills, all the while providing little if any economic benefit to the employer’s economic interests.[6,7] Depending on the law in a particular jurisdiction, some courts may apply a “blue pencil” rule whereby the court may narrow the terms of the covenant to keep the contract in line with applicable state law.[2] Under this type of rule, a judge may use his hypothetical blue pencil to cross out or limit the unreasonable elements of a covenant while leaving the enforceable provisions of the covenant intact.[2]

RESTRICTIVE COVENANTS IN PHYSICIAN EMPLOYMENT CONTRACTS

The use of restrictive covenants in medicine has become more commonplace in recent years because doctors are more likely to change employers than in years past.[10] Prior to 1990, it was estimated that less than two percent of physicians changed jobs during their lifetime.[10] More recent estimates show that approximately ten percent of physicians change their jobs annually.[11] Further, doctors are increasingly seeking employment with large hospitals and health care systems instead of pursuing careers in solo practice.[12] Given the movement toward bigger health care systems where physicians enter into contractual relationships for employment, restrictive covenants have become a ubiquitous component of employment agreements where employers seek to protect their investments in the training and employing of physicians.[13]

Courts usually recognize two primary business interests with respect to restrictive covenants involving physicians: the employer’s investment in specialized training provided to the physician, and protecting a practice’s patient base.[2] Where the employer has been able to demonstrate it has provided valuable medical training that was key to physician’s current marketability and earning potential restrictive covenants have been upheld.[14,15] In like manner, courts in several states have recognized that access to a practice’s “customer” contacts is a protectable interest under a noncompete agreement.[16,17,18]

Courts have determined what qualify as “reasonable” geographic and time limitations on a case-by-case basis. For example, the Supreme Court of New Jersey found that restricting a physician’s practice within a thirty-mile radius of his former employer to be excessive, but changing the radius to thirteen miles would be a reasonable geographic limitation.[14] And in Florida, the state statute on employment noncompete restrictions holds that any restrictive covenant that imposes restrictions of less than six months is reasonable, but a limitation of more than two years is unreasonable.[19]

While many state courts have held physician restrictive covenants to be ethically justifiable when found to not be injurious to the public,[20] and that they can even have a positive impact on patient care,[21] other states do not enforce noncompete agreements for physicians. Delaware and Massachusetts—two states that allow noncompete agreements in employment contracts—do not enforce them against physicians.[2] States such as Virginia, Tennessee, and Texas, however, are simply more critical of physician restrictive covenants than they are of other employment noncompete agreements.[2]

ETHICAL CONSIDERATIONS

A chief concern in the use of restrictive covenants in physician contracts is their impact on patient-physician relationships. Patients have the right to choose their physician (within certain constraints).[22] They are also entitled to continuity of care,[23] and to the extent that restrictive covenants may disrupt continuity, such agreements can be ethically problematic.[24] While a patient may be able to secure care from a different physician in the area or even within the same practice, the trust and confidence established between the patient and his or her original physician may no longer be present.[25] If a noncompete agreement restricts the ability of a physician to enter or leave a market and restricts the scope of the physician's practice, this can erode the number of physicians in a particular region, causing physician shortages and undermining a patient's choice in care.[25] This type of outcome may adversely affect the quality of care in a region or limit access to health care to populations that are already underserved.[24] In terms of employment, restrictive covenants may not adequately recognize the contributions a departing physician has made to a medical practice with regard to his or her professional skills, reputation, and patient relationships, and may overestimate the employer's investment in education and training of that physician.[25] Finally, a noncompete agreement could delay a physician's exit from the physician's current employer, keeping the physician in an unhealthy employment relationship that will have ramifications that reverberate across the practice.[25]

To be ethically justifiable, restrictive covenants must carefully balance the medical needs of individual patients and communities and the business interests of health care organizations. While covenants not-to-compete may seem counterproductive in the medical realm, such agreements can help protect a practice's relationships with its patients, as well as protect monetary and other investments health care organizations and practices make in physician training and mentoring.[26]

RECOMMENDATION

Given these considerations, the Council on Ethical and Judicial Affairs recommends that Opinions E-9.02, "Restrictive Covenants in the Practice of Medicine," E-9.021, "Covenants-Not-to-Compete for Physicians in Training," and E-6.11, "Competition" be amended by substitution as follows in lieu of Resolution 9-A-13 and the remainder of this report be filed:

Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:

- (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
- (b) do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

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APPENDIX

The following opinions are referenced in the report.

E-9.02 Restrictive Covenants and the Practice of Medicine

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII)

Issued prior to April 1977; Updated June 1994 and June 1998.

E-9.021 Covenants-Not-to-Compete for Physicians-in-Training

It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training (residents in programs approved by the Accreditation Council for Graduate Medical Education [ACGME], fellows in ACGME-approved fellowship programs, and fellows in programs approved by one of the American Board of Medical

Specialties specialty boards) should not be asked to sign covenants-not-to-compete as a condition of their entry into any residency or fellowship program. (III, IV, VI)

Issued December 1997 based on the report “Covenants-Not-to-Compete for Physicians-in-Training,” adopted June 1997 (JAMA. 1997; 278: 530).

E-6.11 Competition

Competition between and among physicians and other health care practitioners on the basis of competitive factors such as quality of services, skill, experience, miscellaneous conveniences offered to patients, credit terms, fees charged, etc, is not only ethical but is encouraged. Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely between and among competing physicians and alternate systems of medical care. (VII)

Issued July 1983.

4. HEALTH PROMOTION AND PREVENTIVE CARE

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS EDITORIALLY CORRECTED BY THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AND REMAINDER OF REPORT FILED

See Policy [H-140.843](#).

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing.[1] As members of the medical profession, physicians have obligations to promote patient well-being and to contribute to the betterment of public health.[2,3] Although a physician’s role tends to focus on preventing and treating disease in individual patients, professional medical expertise and experience are needed to promote health in the community as well as among individual patients. Some physicians practice population-based medicine in settings where the diagnosis and intervention occur at the population level, which can also have a direct benefit on the individual patient. Likewise, intervention at the individual patient level can also be necessary to protect the health of the population.

Health promotion has been defined by the World Health Organization as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health.”[4] Promoting health requires more than educating and motivating individuals to engage in healthy lifestyles, as social, environmental and economic conditions may affect health directly and also influence the ability of patients and populations to engage in those healthy behaviors.[5] Health promotion strategies are needed not only for communicable diseases but for prevention of noncommunicable diseases, injury and violence, and mental problems, all of which are found in the global and national lists of the leading causes of death.[6,7] At the level of individual patient care, health promotion strategies through preventive care include, among other modalities, behavioral counseling and health education through a shared decision-making process.

Health promotion through preventive care seeks to reduce the risk of acquiring a disease, arrest its progression or minimize its impact once established.[5] These preventive measures fall into three general categories. Primary prevention aims to prevent disease from occurring, and, at the individual patient level, can include immunizations, behavioral counseling or education about environmental health hazards such as UV radiation or second hand smoke, tobacco use, poor diet, stress, physical inactivity and alcohol consumption, many of which have contributed substantially to morbidity and mortality.[8,9] Secondary prevention refers to improving outcomes through early diagnosis and treatment. For example, screening for mental illness, hypertension or certain cancers and sexually transmitted diseases can facilitate treatment to avoid symptoms, complications or mortality.[10] Tertiary prevention seeks to arrest or reverse the progression of a disease and minimize pain and complications in patients with symptomatic disease (e.g., diabetic nephropathy). Although tertiary prevention includes many aspects of disease management in the clinical setting, it also includes providing patients with resources for managing their disease between encounters with physicians or other professionals.[5] For each type of prevention, physicians need to recognize the health impact of social and environmental conditions in patients’ homes, work settings, communities and hospitals.[5]

While health promotion may include a broad range of participants, physicians play a significant role because of their position at the front lines of health care delivery, where they can serve as trusted role models, counselors, educators, and evaluators for patients.[11] Health promotion and preventive care are fundamental aspects of medicine, and physicians should be competent in these areas to improve the quality of individual patient care as well as to serve the health needs of their communities.

THE PHYSICIAN'S ROLE IN PROMOTING INDIVIDUAL HEALTH

The patient-physician encounter is a critical moment for health promotion and disease prevention. Patients often look first to doctors to promote their health and well-being and expect that physicians will discuss health habits, risk factors and/or screening during health examinations.[12] Indeed, engagement and counseling by physicians has been shown to help patients adopt healthy lifestyle changes and accept preventive care services.[11] Physicians should take advantage of the patient-physician encounter to educate patients about how to minimize risks to health and otherwise fulfill obligations to promote patient well-being and to contribute to the betterment of public health.

Health Promotion as an Integral Part of Practice

As advocates for their patients' overall well-being, physicians should integrate some level of health promotion into their practice.[13] Practices should identify patients in need of health behavior advice and provide these patients with educational materials, resources, appropriate referrals or counseling. Practices serving non-English-speaking patients should ensure that materials are available in multiple languages.[14] When primary care physicians have the practice tools to identify high-risk patients and can link those patients to appropriate specialists or community health resources, evidence indicates that, for example, patients are more likely to engage in healthy practices, such as regular exercise.[15] Some physician practices have experimented with novel methods to encourage health promotion, such as incentive-based programs to encourage healthy lifestyles among patients [16] or delivering vaccines to their community by setting up drive-through flu vaccination.[17]

Physicians should also model a healthy lifestyle, as doing so significantly increases the effectiveness of health promotion counseling to patients.[18] Patients regard counseling physicians who disclose their own healthy habits as more credible and motivating.[18] Physicians can also act as role models by participating in healthy community events such as walks, runs, and immunizations. When possible, physicians should also work with their institutions to help promote healthy campuses and health care facilities so that not just patients but employees, physicians themselves, and those in training have healthy environments.

Physicians responsible for inpatient care should seek to create a health-promoting setting for patients, working with hospital staff to ensure that the patient's physical, emotional and social health needs are satisfied during the inpatient stay.[5] This may include promoting palatable, healthy food in the hospital or relieving patient stress during an inpatient stay.[5]

Risk versus Benefit

As with clinical care, physicians should ensure that interventions relating to health promotion or preventive care are supported by strong evidence of their efficacy.[19] Because preventive services aim not to treat disease but prevent it in the future, the evaluation of risks, burdens and benefits for preventive services must be firmly in favor of benefits. Risks (e.g., drug adverse effects, surgery complications), and burdens (e.g., pain, patient time and trouble) can often be justified when treating illness, even when the benefit of the intervention is far from certain, since failing to intervene often carries greater risks and burdens. Evidence-based preventive care guidelines have already been issued by the US Preventive Services Task Force,[10] and other organizations (e.g., American Academy of Family Physicians, American College of Physicians, American Congress of Obstetricians & Gynecologists, and American Academy of Pediatrics).

Individualized Preventive Care

Physicians should familiarize themselves with how preventive care guidelines differ for different patient groups.[10] Beyond those differences, physicians should recognize that health promotion sometimes needs to be tailored to the patient's needs and preferences and, for health behaviors, readiness to change.[20] A patient with heart disease, for instance, might reasonably prioritize quitting smoking over colon cancer screening or weight loss. Collaborative,

patient-centered prevention affirms the patient's autonomy, recognizes the patient's fundamental role in implementing recommendations, and promotes trust.[21]

Physicians should also be aware of how individual patient circumstances may impact the effectiveness of health promotion efforts. Some patients may have difficulty with transportation, accessibility or mobility, or may have financial obstacles that affect their ability to follow given recommendations. They may not have the ability to safely exercise, may not be able to provide payment for health services or vaccinations or may be unable to access healthy food.[22] Physicians should encourage patients to be transparent about such difficulties in order for the physician to recommend less burdensome alternatives and maximize the ability of the patient to follow recommendations that could prevent illness. Physicians should also ask about work or living conditions that may expose the patient to health hazards, such as occupational exposures and interpersonal violence, and discuss ways to avoid or mitigate the harm or refer the patient to appropriate resources in the community.[23] Stress and mental health should also be addressed.

When they lack the time, resources or skills to provide the patient with adequate counseling physicians may refer a patient to resources in the community such as the YMCA's Diabetes Prevention Program or appropriate allied health professionals for targeted counseling for exercise or nutrition. Indeed, behavioral interventions that involve allied health professionals may be more effective in producing sustained behavioral changes than those that solely involve a primary care physician.[24] Even after referral, the physician should continue to assist the patient's behavioral change and conduct follow-ups when appropriate.

Health Promotion & the Specialty Physician

While primary care physicians are typically a patient's main source for health promotion efforts, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when the recommendation is relevant to the condition that physician is treating. A specialist who has regular contact with a patient who rarely sees other physicians can have a stronger ethical responsibility to incorporate health promotion efforts (even if it is not related closely to the condition under treatment) into specialty care. Specialists who do not see a patient frequently should, at a minimum, confirm that the patient has had health maintenance visits with his/her primary care physician, and should recommend follow-up with the primary physician when appropriate.

Physicians in Public Health Roles

While all physicians must balance a commitment to individual patients with the health of the public, many physicians practice specifically in the area of public health. As CEJA has noted in an earlier report, "The Use of Quarantine and Isolation as Public Health Interventions" (CEJA 1-I-05), physicians serving in this capacity must uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies. Standards of medical ethics place great emphasis on respect for patients' autonomy and right to self-determination. This stands in contrast with some public health measures, which may authorize restricting individual liberties in times of public peril (e.g. quarantine or isolation), and override patient autonomy in order to protect the health of the population. From the report:

Physicians, in collaboration with public health officials, must first assess the relative risks posed by a communicable disease as compared with the potential positive and negative consequences resulting from public intervention. When intervention appears warranted, public efforts must be applied fairly and undertaken in a manner that minimizes any potentially deleterious consequences at the individual level. Finally, the undertaking of any intervention must be sufficiently transparent in nature so as to enable the public to understand the need for public health measures and to participate in the planning process. By adhering to these ethical guidelines, members of the medical profession can help ensure that quarantine and isolation measures achieve their public health goals and maximally promote the well-being of individuals.

THE PHYSICIAN'S ROLE IN POPULATION HEALTH

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world. Public health also emphasizes reducing health

disparities. Population health is defined as “the health outcomes of a group of individuals – including the distribution of such outcomes within the group.”[60] The medical and public health sectors need close working relationships in order to combat major health issues and accelerate health promotion in communities throughout the nation.[13] Public health departments naturally emphasize public or community education, while physicians emphasize educating and motivating patients to adopt healthier lifestyles and to utilize appropriate preventive care services.[25] When public health attends to access to health care, or mitigating health disparities, collaboration with health care professionals and organizations is crucial. Even population disease surveillance, a core function of public health, relies on proper diagnosis and reporting by medical professionals. Indeed, for novel or emerging public health problems, astute clinicians providing information can be integral in the development of diagnostic tests, treatments and preventive measures. Physicians should be aware of local community needs and work toward achieving the community’s public health goals.[13]

Physicians should consider the health of the community when treating their own patients. For example, physicians should prioritize and strongly urge flu shots for patients who regularly interact with vulnerable segments of the population, including teachers, health care workers and household contacts of children or seniors.[26] When individual patients experience preventable medical problems, the community’s health deteriorates as medical resources are diverted from other areas of care.[27] Physicians who implement effective preventive care practices help minimize the burden on the health care system from unnecessary hospitalizations and facilitate recovery of patients with chronic diseases, consistent with their duties to patients and upholding their responsibility to be prudent stewards of health care resources.[19]

Beyond patient care, physicians are responsible for adhering to public health policies and laws that safeguard the health of a community. Physicians should be aware of the responsibility to identify and notify public health authorities about patterns in patient health that may indicate the outbreak of an infectious disease,[28] or the emergence of an environmental hazard such as lead poisoning.[29] They should also be ready to respond to disasters or public health emergencies, and are encouraged to assist with local response planning.[30] Physicians are also encouraged to take on leadership roles in public health [31] and to contribute to health promotion research by describing and sharing their observations on the effectiveness of health promotion and preventive care programs or interventions.[32]

CONDITIONS FOR SUCCESSFUL HEALTH PROMOTION EFFORTS

The successful implementation of health promotion efforts by physicians in clinical practice is dependent on several conditions. Coordination of health care is an important element that has been shown to aid in these efforts, as have other conditions, such as physicians acting as role models for their patients and exhibiting health promoting behaviors. Barriers to the successful adoption and implementation of health promoting practices in health care settings have also been identified. These may include lack of appropriate insurance coverage, physician resources, education and training, and diminishing local public health capacity. Patients themselves may also have limitations that impact how well they can adhere to health promoting behaviors and other measures suggested by a physician.

Coordination of Health Care

It is particularly important to coordinate health promotion efforts among a variety of health care professionals. Nurses and allied health professionals often play an important role in counseling and educating patients and implementing other health promoting practices.[5] Under some hospital discharge programs, nurses or pharmacists educate patients, reconcile patient medications, and communicate frequently with patients. These types of coordinated care efforts have been linked to fewer post-discharge hospitalizations and readmissions.[33-35] All health professionals should be trained to deliver preventive care in an inter-professional team-based setting.[36]

Resource Obstacles

Many physicians are concerned about having limited time and inadequate reimbursement for some valuable health promotion services [37-39] such as counseling. In one study where patients were all eligible and due for the receipt of at least five preventive health services, results showed that time constraints likely forced both physicians and patients to decide which topics to ultimately address. Perhaps not surprisingly, the likelihood of addressing health promotion issues decreased with each additional health concern a patient expressed. At the point when physicians did address health promotion and disease prevention, the physicians seemed to prioritize cancer screening over

counseling services, immunizations, or other health promotion efforts.[38] Appropriately designed compensation programs may encourage more physicians to conduct behavioral counseling.[40] The medical profession should also advocate for policies to support evidence-based health promotion and preventive services including counseling and follow-ups.[36] In addition, patients can also face financial obstacles to preventive services. Physicians should encourage their patients to be forthcoming about any relevant obstacles that affect their ability to engage in healthy behaviors, such as work and family life, mental health, general safety, and financial resources.

Knowledge, Skills & Training

Training in health promotion techniques should be reinforced in medical education;[32] physicians cite a lack of confidence, knowledge or skill as a major barrier to conducting behavioral counseling with patients.[41] Exposure to preventive care during clinical rotations seems to provide medical students with practical, beneficial knowledge in this area, particularly regarding patient education and counseling, which is an important prevention strategy.[42] Continuing medical education also needs to include updates on the evidence and skills related to health promotion. Training workshops and the provision of screening and charting tools have been shown to greatly improve screening and behavioral counseling rates among physicians.[43] For example, established and endorsed competencies from the American College of Preventive Medicine and the American College of Lifestyle Medicine provide tools for leadership, knowledge, assessment and management skills, and use of office and community support.

Effective communication skills are closely tied to the physician's ability to motivate patients to adopt healthy behaviors,[44] undergo appropriate screening [45] and adhere to medication [46]—all significant aspects of preventive care. Obviously, excellent communication skills also contribute to quality clinical care outside of prevention and can help build and maintain trusting relationships with patients. Efforts to improve physicians' communication skills should begin as early as medical school [47] and continue through a physician's career. Some research shows that communication skills may not reliably improve with experience, and that there are both effective and ineffective communication skills training programs.[48] Significant efforts should include improving these skills in the interest of the patient and the relationship with their physician.[48]

THE PROFESSION'S ROLE IN PROMOTING HEALTH AND PREVENTION

Advocacy

The medical profession should assist the public health sector in promoting healthier communities through advocacy by medical associations and their members. For example, medical associations may collaborate with public health organizations and others to improve access to care,[49] call for greater health consciousness and corporate social responsibility in the food and beverage industry,[50,51] or seek policies or initiatives to reduce health care disparities.[14] Physicians in county medical societies may reach out to employers to promote healthy workplace environments,[52] work with community organizations to develop health promotion programs and services,[53] or work to ameliorate factors that may contribute to unhealthy habits or poor health, such as accessibility to healthy foods in schools,[54] education, homelessness or poverty, lack of family or social supports, violent or unwalkable neighborhoods, and food deserts.[55-58]

Developing Evidence for Health Promotion Strategies

The development of appropriate standards, tools, measures and strategies would help improve and reduce unnecessary variation in health promoting practices [48]. The medical profession, including medical associations and their members, should support further research on approaches to integrating health promotion into health care delivery systems. Physicians engaged in such studies should adhere to the appropriate standards of ethical conduct of research.[16,59] Other areas of study that would influence the effectiveness of health promotion efforts are the impact of various purchasing strategies and regulatory incentives on encouraging health promotion, relevant guidelines and performance measures for quality assurance or improvement programs, monitoring and accountability tools, and databases that can facilitate sharing health information.[50]

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. Physicians have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians' duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patient's main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

- (a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
- (b) Educate patients about relevant modifiable risk factors.
- (c) Recommend and encourage patients to have appropriate vaccinations and screenings.
- (d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
- (e) Collaborate with the patient to develop recommendations that are most likely to be effective.
- (f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
- (g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
- (h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

- (i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
- (j) Advocate for healthier schools, workplaces and communities.
- (k) Create or promote healthier work and training environments for physicians.
- (l) Advocate for community resources designed to promote health and provide access to preventive services.
- (m) Support research to improve the evidence for disease prevention and health promotion.

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5. PROFESSIONALISM IN TELEMEDICINE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-480.974 instructs the Council on Ethical and Judicial Affairs (CEJA) to review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate.

After a thorough review of the literature and of current policies regarding telemedicine, telehealth, and communications between a patient and a physician both in the context of and prior to a formal relationship, CEJA has concluded that the request to review current related Opinions raises broader ethical questions surrounding appropriate physician behavior in these contexts. A strong ethical analysis of this scope should examine the following main issues:

- key elements of a patient-physician relationship
- appropriate use of telemedicine and telehealth technologies within an ethical framework
- elements such as informed consent, prescribing, disclosure, and continuity of care

The report that led to the policy requested that a report be presented to the AMA House of Delegates at its 2014 Annual Meeting. However, to ensure sufficient opportunity to adequately explore these far-reaching issues with other interested parties, CEJA will continue its deliberations and submit its final report at the 2014 Interim Meeting.

6. IMMUNIZATION EXEMPTIONS FOR PHYSICIANS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

Policy D-440.936 “Immunization Exemptions for Physicians,” asks our AMA to “review and address existing inconsistencies in its policies regarding immunization exemptions.”

In partnership with the Council on Science and Public Health (CSAPH), the Council on Ethical and Judicial Affairs (CEJA) has conducted a thorough review of current AMA immunization policies, as well as examined extensive evolving literature and data on immunization exemptions in the United States concerning physicians, health care professionals, and the general public. Exempting physicians and other health care professionals from immunizations raises significant ethical and scientific issues of personal autonomy, public health and the responsibilities of health care professionals.

To ensure that these issues are explored in a thoughtful and comprehensive manner as the foundation for consistent policy in this area, CEJA will continue its deliberations, in conjunction with CSAPH and key stakeholders, with a final report at the 2014 Interim Meeting.

7. JUDICIAL FUNCTION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS: ANNUAL REPORT

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the [Principles of Medical Ethics](#) or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/governing-rules/rules-review-membership.page.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA’s activities during the most recent reporting period is presented.

APPENDIX - CEJA Judicial Function Statistics

APRIL 1, 2013 ~ MARCH 31, 2014

Physicians Reviewed	<i>SUMMARY OF CEJA ACTIVITIES</i>
4	Determinations of no probable cause
38	Determinations following a plenary hearing
28	Determinations after a finding of probable cause, but without a plenary hearing
Physicians Reviewed	<i>SUMMARY OF CEJA ACTIVITIES</i>
4	Determinations of no probable cause
38	Determinations following a plenary hearing
28	Determinations after a finding of probable cause, but without a plenary hearing
Physicians Reviewed	<i>DETERMINATIONS (by type of action taken)</i>
17	No sanction or other type of action
8	Monitoring
10	Probation
10	Revocation
4	Suspension
0	Resignation accepted
1	Application denied
17	Censure/Admonishment/Reprimand
3	Application withdrawn
Physicians Reviewed	<i>PROBATION/MONITORING STATUS</i>
18	Members placed on Probation/Monitoring during reporting interval
9	Members placed on Probation without reporting to Data Bank
3	Probation/Monitoring concluded satisfactorily during reporting interval
66	Number of physicians on Probation/Monitoring at any time during reporting interval who have paid AMA membership dues
17	Number of physicians on Probation/Monitoring at any time during reporting interval who have not paid AMA membership dues

8. CEJA'S SUNSET REVIEW OF 2004 HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee on Amendments to Constitution and Bylaws](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AND
REMAINDER OF REPORT FILED**

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- Each year the House policies that are subject to review under the policy sunset mechanism are identified.

- Policies are assigned to appropriate Councils for review.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
- A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

2004 POLICIES

In this report, the Council on Ethical and Judicial Affairs presents its recommendations regarding the disposition of 2004 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning and Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies that originate from CEJA Reports and duplicate current opinions issued since June 2005. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. After the corresponding CEJA Opinion is issued, CEJA utilizes its annual sunset report to rescind the duplicative House policy.

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, "Pediatric Decision-Making." It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council's 2009 sunset report.

The Appendix provides recommended actions and their rationale on House policies from 2004, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

Policy No.	Title	Recommended Action & Rationale
D-100.990	Patient Privacy and Pharmaceutical Sales Representatives	Rescind: Policy no longer relevant
D-315.989	Protecting Patient Privacy Against Federal, State or Local Governmental Intrusion	Rescind: Policy no longer relevant
D-460.982	AMA Advocacy for Federal Funding on the Ethical, Legal, and Social Implications (ELSI) of Bioterrorism Preparedness and Research	Rescind: Policy no longer relevant
H-140.898	Medical Profession Opposition to Physician Participation in Execution	Retain: Policy remains relevant

H-140.938	Professional Courtesy	Rescind: Policy no longer relevant
H-140.950	Physician Participation in Capital Punishment	Retain: Policy remains relevant
H-140.963	Secrecy and Physician Participation in State Executions	Retain: Policy remains relevant
H-140.999	Our AMA and Bioethics	Retain: Policy remains relevant
H-265.990	Expert Witness Affirmation	Retain: Policy remains relevant
H-265.992	Expert Witness Testimony	Retain: Policy remains relevant
H-270.961	Medical Care Must Stay Confidential	Retain: Policy remains relevant
H-65.997	Human Rights	Retain: Policy remains relevant
H-140.873	The Use of Quarantine and Isolation as Public Health Interventions	Rescind: Duplicates existing ethics policy